INSTRUCTIONS FOR COMPLETION OF THE HFS 1409 (R-03-09) PRIOR APPROVAL REQUEST FORM

Revised April 2009

THIS FORM REPLACES THE EXISTING HFS 1409 AND HFS 2240

ALL FIELDS ARE REQUIRED TO BE COMPLETED UNLESS OTHERWISE NOTED.

1. **RECIPIENT ID NUMBER** – Enter the nine-digit recipient identification number assigned to the patient for whom the service or item is requested. This number is found to the right of the patient's name on the back of the Medical Programs Card.

2. **RECIPIENT NAME** – Enter the name of the patient for whom the service or item is requested.

3. **BIRTHDATE** – Enter the patient's birthdate.

4. **PROVIDER/NPI #** - Enter the provider number or NPI number as shown on the Provider Information Sheet.

5. **PROVIDER TELEPHONE #** - Enter the telephone number of provider's office. This information is helpful in instances where the Department needs additional information in order to act upon the request.

6. **PROVIDER NAME** – Enter the name of the provider who will provide the service or item.

7. **PHYSICIAN NAME** – Enter the name of the physician or other provider who signed the order or prescription recommending that the patient receive the specific item or service.

8. **PROVIDER STREET ADDRESS** – Enter the address of the provider.

9. **PHYSICIAN STREET ADDRESS** – Enter the address of the ordering practitioner.

10. **PROVIDER CITY, STATE, ZIP CODE** – Enter the address of the provider.

11. **PHYSICIAN CITY, STATE, ZIP CODE** – Enter the address of the ordering practitioner.

12. **DIAGNOSIS CODE** – Enter the ICD-9-CM diagnosis code that corresponds to the description listed in item 14 below.

13. **ADDITIONAL DIAGNOSIS** – Enter additional ICD-9-CM diagnosis codes, if applicable.

14. **DIAGNOSIS DESCRIPTION** – Enter the written description, which corresponds with the diagnosis code listed in item 12.

15. **PATIENT HEIGHT/WEIGHT** – This field is required for durable medical equipment/supply requests and for gastric bypass procedures.

16. **PROCEDURE CODE** – Enter the five-digit HCPCS or CPT code that identifies the specific item/service being requested. For in-home shift nursing – enter procedure code G0154 or G0156. For podiatry – if a quantity of two is requested (for instance, right and left), list the specific HCPCS code for the first, then 99199 for the second.

    DESCRIPTION – Briefly describe the services or items or materials to be provided. For home health services specify if the services requested are either intermittent visits or hourly in-home shift nursing. Provider's workweek must be indicated for in-home shift nursing. For therapy services enter frequency, duration and service time frames.

    QTY – Enter the number of items to be dispensed in the time period covered by the prior approval request or enter the number of times the service is to be performed. For therapy services enter the number of units requested. 1 unit = 15 mins.

    CAT. SERV – Enter the two-digit category of service (COS) code corresponding to the related item/service. Valid entries are:
    01 (Physician Services) 04 (Podiatric Services)
    11 (Physical) 12 (Occupational) 13 (Speech) Therapy Services
    41 (Medical Equipment/Prosthetic Devices) 45 (Optical Supplies)
    48 (Medical Supplies) 66 (Home Health Services)

    PROV CHARGE – Enter the total amount to be charged for the item being requested.

    APPROVED HFS AMT – Leave blank.

    BEGIN DATE – If an item or service has already been dispensed, enter the date the item or service was provided. If item or service will not be provided until the prior approval is granted, leave blank.

    END DATE – Indicate the ending date of service, if applicable.

    PUR/RENT – For medical equipment/supplies enter P for purchase or R for rental. All other providers enter P.

    MOD – To be used for modifiers at a later date.

17 – 20. To be used for additional procedures. If you list more than 5 procedures another request must be submitted.

21. **ADDITIONAL MEDICAL NECESSITY** – To be used for other medical information. For optical - in addition to a narrative explanation, diagnosis and visual acuity both with and without glasses should be provided.

22. **APPROVING AUTHORITY SIGNATURE** – used by the Dept of Children and Family Services to authorize in-home shift nursing.

23. **PROVIDER SIGNATURE/DATE** – To be signed in ink by the individual who is to provide the service.

MAILING INSTRUCTIONS

Before mailing, carefully review the request for completeness and accuracy. The signed copy of the HFS 1409 may be mailed to:

Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health Services
Post Office Box 19124
Springfield, Illinois 62794-9124

A copy may be retained in the provider's records.

A notification of approval or denial of the service(s) will be mailed to the provider and patient.

FAX INSTRUCTIONS

The signed copy of the HFS 1409 may be faxed Monday through Friday, 8:30 AM – 5:00 PM, excepting holidays, to the following numbers.
Optometric requests – 217-524-7120
All other requests – 217-524-0099